VILLAGE OF CEDARHURST
STATE HANDICAPPED PARKING PERMIT APPLICATION
200 CEDARHURST AVENUE, CEDARHURST, NY 11516

PART I (To be completed by applicant) PLEASE PRINT

Applicant's Name_____

Address_____
You must provide proof of residency if name does not appear on our tax roll

Date of Birth_____**Telephone #**_____/_____/_____
Home Business Cell

Drivers License I.D. No._____
and copy of license

I hereby certify that the above statements are true, and authorize the physician named in Part II to furnish any information to this office concerning the diagnosis, prognosis and treatment of my described condition.

I further acknowledge that I have read and understand the conditions of this application and the Handicapped Parking Permit, and I shall observe and comply with same.

Date_____ _____
Signature of Applicant or Guardian

PART II (To be completed by a MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY)

Physician's Name_____**License #** _____

Address_____**Phone #**_____

_____**has one or more of the following impairments:**
ANSWER ALL FOUR QUESTIONS:

1. **Please check applicable condition(s):**

   _____**limited or no use of one or both lower limbs.**

   _____**neuro-muscular dysfunction which severely limits mobility.**

   _____**physical or mental impairment or condition which is other than those specified above, but imposes unusual hardship in utilization of public transportation facilities and such condition prevents applicant from getting around without great difficulty.**

   _____**a blind person.**

2. **Please describe handicapped condition:**_____

   _____

3. **Describe limitations in ambulation (include use of walking aids)** _____

   _____

4. **This condition is**_____**Permanent**_____**Temporary.**
   If temporary, please indicate the approximate length of time your patient will require the permit _____
   months.

I am an MD or a DO, licensed to practice in New York State, and in my professional opinion, I believe the applicants condition does warrant a Handicapped Parking Permit.

_____
Signature of Physician (no stamp accepted)

Date_____